

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE BOARD OF DENTISTRY

In the Matter of the Dental License of  
Robert L. Bodin, D.D.S.  
License No. D7172

**FINDINGS OF FACT,  
CONCLUSIONS,  
AND RECOMMENDATION**

The above-entitled matter came on for hearing before Administrative Law Judge Steve M. Mihalchick on March 9, 2009, at the Office of Administrative Hearings in St. Paul, Minnesota. The hearing continued on four subsequent days and concluded on March 13, 2009. The OAH hearing record closed on May 18, 2009, upon receipt of the parties' final written memoranda.

Careen Martin and Daphne Lundstrom, Assistant Attorneys General, Suite 1400, 445 Minnesota Street, St. Paul, Minnesota 55101-2131 appeared on behalf of the Complaint Committee ("Committee") of the Minnesota Board of Dentistry ("Board").

William Skolnick and Jessica Savran, Attorneys at Law, Skolnick & Shiff, P.A., 2100 Rand Tower, 527 Marquette Avenue South, Minneapolis, Minnesota 55402, appeared on behalf of the Respondent, Robert L. Bodin, D.D.S ("Respondent").

**STATEMENT OF ISSUES**

1. Did the Respondent engage in conduct unbecoming a person licensed to practice dentistry by repeatedly performing dental treatments that fall below accepted standards within the meaning of Minn. Stat. § 150A.08, subd. 1(6) and Minn. Rule 3100.6200B?

(a) Did the Respondent fail to provide appropriate endodontic treatment to Patients 4, 8, and 10?

(b) Did the Respondent fail to take a sufficient number of radiographs and/or fail to take radiographs of sufficient diagnostic quality to properly assess patients' dental health?

(c) Did the Respondent fail to make or maintain adequate patient records on Patient 1-11 within the meaning of Minn. R. 3100.9600?

2. Did the Respondent engage in unprofessional conduct when he knowingly allowed patients under conscious sedation to go without continuous active monitoring

by a dentist certified in administration of conscious sedation, and when he monitored patients under conscious sedation without completing the required training and education for conscious sedation practice?

3. Did the Respondent fail to maintain adequate safety and sanitary conditions for the dental office located at 5401 Chicago Avenue in Minneapolis, Minnesota within the meaning of Minn. Stat. § 150A.08, subds. 1(6) and (10) and Minn. R. 3100.6200K and 3100.6300?

4. Does the Respondent's conduct justify the Board of Dentistry imposing disciplinary action against the Respondent?

Based on the testimony, records, and arguments in this matter, the Administrative Law Judge makes the following Findings of Fact:

## **FINDINGS OF FACT**

### **The Respondent's Practice**

1. The Respondent, Robert L. Bodin, D.D.S., graduated from the University of Minnesota Dental School and has been licensed to practice dentistry since 1967.<sup>1</sup> Respondent is the president, CEO, and sole owner of 13 dental clinics that he operates under the name Family & Cosmetic Gentle Dentistry.<sup>2</sup> The clinics are located throughout the Twin Cities, surrounding suburbs, and west central Minnesota.<sup>3</sup> Respondent practices primarily at his Edina and Spring Park locations.<sup>4</sup> In December 2005 through January 2006, the Respondent's practice employed approximately 12 dentists and 50-60 other employees.<sup>5</sup>

2. The Respondent's practice services a high number of low-income patients including those eligible for Medical Assistance ("MA").<sup>6</sup> In 2005, approximately half of Respondent's 20,000 patients were on MA and the ratio has remained about the same ever since. In 2006, the number of Respondent's patients on MA was 12,000, and by 2007 more than 16,000 of Respondent's patients were MA patients. In 2008, the

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<sup>1</sup> Transcript ("T.") 48-49

<sup>2</sup> T. 595, 601.

<sup>3</sup> T. 49-50. The clinics are located at 5401 Chicago Avenue South in Minneapolis; 4787 Shoreline Drive in Spring Park; 5200 Eden Avenue in Edina; 5101 Winnetka Avenue in New Hope; Xenium Lane in Plymouth; Duckwood Plaza in Eagan; Suburban Square in St. Paul; Hutchinson Mall in Hutchinson; Springbrook Mall in Coon Rapids; Alexandria Mall in Alexandria, and Cottage Grove. Ex. 106 at 2. Respondent is the employer and "boss" of all Family & Cosmetic Gentle Dentistry employees. T. 594-595.

<sup>4</sup> T. 49-50.

<sup>5</sup> Ex. 106 at 2; T. 539. In 2009, Family & Cosmetic Gentle Dentistry employs 20 dentists and 110 other employees. T. 539.

<sup>6</sup> T. 41 and 797-798. (Dr. Bodin estimates that his practice is the third largest provider for medical State-funded insurances.)

Respondent's practice had approximately 44,000 patients and of those, over 20,000 were on MA.<sup>7</sup>

### Expert Witnesses

3. Dr. Nelson L. Rhodus provided expert testimony regarding the minimum standard of acceptable and prevailing practice for dental treatment. Dr. Rhodus has been licensed to practice dentistry in Minnesota since 1986 and is currently a full professor and division director of oral medicine, oral diagnosis, and oral radiology in the Department of Diagnostic and Biological Sciences at the University of Minnesota School of Dentistry.<sup>8</sup> Dr. Rhodus teaches all four years of dental school curriculum, including principles of oral medicine, diagnosis, oral radiology, and introduction to oral pathology.<sup>9</sup> Dr. Rhodus currently practices dentistry and is board-certified in oral medicine.<sup>10</sup>

4. Dr. Rhodus also teaches continuing education courses, conducts research, and is a published author, consultant, and expert witness for plaintiffs and defendants in prior Committee actions.<sup>11</sup> Dr. Rhodus' expert witness consulting generally focuses on oral diagnosis, oral medicine, recordkeeping, and radiographs.<sup>12</sup> Dr. Rhodus has published articles on the minimum standards of acceptable and prevailing practice for infection control and safety, and has served as the Infection Control Committee chair and safety officer for the University of Minnesota School of Dentistry.<sup>13</sup>

5. Dr. James Q. Swift testified as an expert witness regarding the standard of care required for the administration of conscious sedation. Dr. Swift has been a licensed dentist in Minnesota since 1989 and is also licensed by the states of Florida and Oklahoma.<sup>14</sup> Dr. Swift presently serves as a full professor and division director of oral and maxillofacial surgery at the University of Minnesota School of Dentistry.<sup>15</sup> In that capacity, Dr. Swift trains dental students, coordinates academic and residency training programs, conducts research, and writes scholarly papers.<sup>16</sup> He also administers the clinical component of the oral and maxillofacial surgery division and is responsible for safety and training program procedures.<sup>17</sup> Part of his teaching responsibilities involves training residents in the oral and maxillofacial surgery program on how to perform conscious sedation.<sup>18</sup> In addition, Dr. Swift conducts continuing education programs for licensed dentists, which may involve conscious sedation

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<sup>7</sup> T. 41 and 616.

<sup>8</sup> T. 290.

<sup>9</sup> T. 290-291; Ex. 121, 2.

<sup>10</sup> T. 291.

<sup>11</sup> T. 291-93.

<sup>12</sup> T. 292-93.

<sup>13</sup> T. 856.

<sup>14</sup> T. 77; Ex. 122, 2.

<sup>15</sup> T. 80; Ex. 122, 1-2.

<sup>16</sup> T. 80.

<sup>17</sup> T. 80-81.

<sup>18</sup> T. 88-90.

training, and is active in national associations and organizations in his field.<sup>19</sup> Dr. Swift is board-certified in oral and maxillofacial surgery.<sup>20</sup>

6. Dr. Swift's involvement with Minnesota and national associations includes establishing standards in oral and maxillofacial surgery and anesthesia and evaluating the adherence of educational programs and surgeons to those standards.<sup>21</sup> Dr. Swift also instructs dental students at the University and practicing dentists in continuing education programs on the performance of conscious sedation and presents and lectures throughout the country on the technique.<sup>22</sup>

7. The Respondent did not present any expert testimony, other than his own, regarding the standard of care.

## **Patient Treatment/Minimum Standard of Care**

### **Radiographs**

8. A radiograph is a hard copy image of an X-ray.<sup>23</sup> Technological advances may change the format to electronically stored images, but in dentistry, radiographs in some form are an essential part of making a diagnosis. Because the oral cavity contains hard tissues that are opaque and cannot be seen completely with the naked eye, radiographs are necessary to expose the underlying hard tissue.<sup>24</sup> To meet the minimum standard of care, radiographs must be of sufficient quality to give an accurate representation of the particular area being diagnosed.<sup>25</sup> The doctor is responsible for the adequacy of the radiographs in a dental practice.<sup>26</sup>

9. The minimum standard of care also requires an interpretation of the dentist's findings on the radiograph. The patient file should include not only the radiograph, but also documentation of what is interpreted on the radiograph.<sup>27</sup> The standard of care in dentistry also requires that providers have both a preoperative radiograph and a postoperative radiograph.<sup>28</sup> It is necessary to take a postoperative radiograph of a tooth to ensure that the dental procedure was performed adequately and to the degree desired by the provider.<sup>29</sup>

10. The Respondent provides root canal treatment as part of his practice. Root canal treatment involves entering the pulp of the tooth to clean out the diseased,

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<sup>19</sup> T. 81.

<sup>20</sup> Ex. 122.

<sup>21</sup> T. 82-83.

<sup>22</sup> T. 84-90.

<sup>23</sup> T. 302.

<sup>24</sup> T. 308.

<sup>25</sup> T. 313.

<sup>26</sup> T. 313.

<sup>27</sup> T. 313, 343-344.

<sup>28</sup> T. 808.

<sup>29</sup> T. 344.

infected or necrotic tissue and disinfecting the canal so that it is suitable for the placement of filling material.<sup>30</sup>

11. During root canal therapy, the minimum standard of care requires that a radiograph be taken preoperatively to make sure that there is in fact a problem with the pulp of the tooth (disease or infection) and to determine the extent of the problem.<sup>31</sup> A view of the apex of the tooth is necessary to determine whether the tooth is healthy on the root's tip or whether there is evidence of some disease process.<sup>32</sup> After the procedure, the minimum standard of care requires that a post-operative radiograph is taken to make sure that the provider has gone all the way to the tip of the tooth's root in the pulp and removed all of the diseased, infected or necrotic tissue.<sup>33</sup>

## **Recordkeeping**

12. The purpose of recordkeeping is to make sure that there is a documented diagnosis and a rationale for care that is appropriate and necessary, and to document that it has been properly performed.<sup>34</sup> The minimum standards of acceptable and prevailing practice for recordkeeping and the Board's rule governing dental recordkeeping are essentially the same.<sup>35</sup> The minimum standards of acceptable and prevailing practice with respect to dental recordkeeping require that the dentist collect the minimum amount of information necessary to inform a diagnosis, document the care rendered, and document the outcomes that would arise from the care provided.<sup>36</sup> Documentation of the care provided is part of a patient's comprehensive care.<sup>37</sup>

13. If a dental health provider uses abbreviations in a patient record, the provider should maintain an index in the record itself so that other providers can understand what the abbreviations mean.<sup>38</sup> In addition, all information should be in the patient's record so that subsequent providers will know what treatments, procedures, options, or diagnoses were offered or rendered.<sup>39</sup>

14. Dental records must also include documentation that the dentist discussed treatment options, benefits and risks with the patient, and that the patient consented to the treatment chosen.<sup>40</sup>

15. On several occasions, the Respondent failed to note in a patient's file that he had obtained the patient's informed consent prior to performing dental services.<sup>41</sup>

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<sup>30</sup> T. 348.

<sup>31</sup> T. 343.

<sup>32</sup> T. 322-323.

<sup>33</sup> T. 343-345.

<sup>34</sup> T. 298-299.

<sup>35</sup> T. 297. See Minn. R. 3100.9600.

<sup>36</sup> T. 298-299.

<sup>37</sup> T. 299.

<sup>38</sup> T. 899.

<sup>39</sup> *Id.*

<sup>40</sup> See Minn. Rule 3100.9600, subp. 9.

## Patient #1

### Recordkeeping<sup>42</sup>

16. Patient #1 received dental care from the Respondent from August 1987 until November 2008.<sup>43</sup> Between 2004 and 2006, Respondent replaced crowns for Patient #1 and performed root canal treatments.<sup>44</sup>

17. Respondent's progress notes for Patient #1 from November 5, 2004, do not contain a chief complaint.<sup>45</sup> The progress notes also refer to a crown preparation but do not identify which tooth is being prepared for a crown. In addition, the notes contain a pulp diagnosis but do not contain a diagnosis for the tooth itself.<sup>46</sup> The notes do not identify all of the materials used by the Respondent, do not indicate if an anesthetic was used, and do not contain a notation that the Respondent discussed treatment options with or obtained consent from Patient #1.<sup>47</sup>

18. Patient #1's records also contain several discrepancies related to an entry dated November 3, 2004. First, the record indicates that that entry was made after the November 5<sup>th</sup> entry.<sup>48</sup> Second, there are two pages containing a November 3, 2004 entry that are identical except for the date noted after the entry. On one page, the date "11/19" follows the November 3<sup>rd</sup> entry. On the other page, the date "12/7/04" follows the November 3<sup>rd</sup> entry.<sup>49</sup> Having two non-identical progress note pages dated November 3, 2004, makes it difficult to determine Patient #1's diagnosis and follow-up treatment procedures.<sup>50</sup> The records also feature a treatment plan that lacks any notation regarding the services provided in November or December 2004.<sup>51</sup> And a radiograph in Patient #1's record bears only the date "11/19," making it impossible to determine accurately what year the radiograph was taken.<sup>52</sup> Finally, Patient #1's records contain two informed consent forms that lack a signature or other indication that Patient #1 consented to the care provided.<sup>53</sup>

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<sup>41</sup> T. 680-681, 711.

<sup>42</sup> The Committee offered evidence to support a claim that Respondent's radiographs for Patient #1 were of sub-standard diagnostic quality. However, there are no allegations in the Second Amended Notice and Order for Hearing that the Respondent's radiographs for Patient #1 failed to meet the minimum standard of acceptable and prevailing practice. The allegations concerning Patient #1 are limited to sub-standard recordkeeping..

<sup>43</sup> Ex. 100, Pt. #1, p. 1-2.

<sup>44</sup> *Id.* at 3-5; T. 314-322.

<sup>45</sup> Ex. 100, Pt. #1, p. 5, T. 314.

<sup>46</sup> *Id.*; T. 314-315.

<sup>47</sup> *Id.* T. 317-320.

<sup>48</sup> *Id.* at 4, T. 317.

<sup>49</sup> *Id.* at 4, 4A; T. 319.

<sup>50</sup> T. 319-320.

<sup>51</sup> Ex. 100, Pt. #1, p. 24; T. 320-321.

<sup>52</sup> T. 323-24; Ex. F.

<sup>53</sup> *Id.* at 45, 48; T. 321-22.

19. Respondent's recordkeeping for Patient #1 failed to meet the minimum standards of acceptable and prevailing practice.<sup>54</sup>

## **Patient #2**

### **Recordkeeping**

20. Patient #2 received dental care from the Respondent from January 2001 until at least January 2005.<sup>55</sup>

21. On November 19, 2002, Patient #2 saw the Respondent for construction of a temporary crown on tooth 5. Respondent's progress notes do not identify all of the materials used for the procedure or how the crown was cemented in place.<sup>56</sup>

22. Respondent's progress notes for December 8, 2002, do not indicate the reason for Patient #2's visit on that date, document a clinical examination, a diagnosis, a treatment plan, or Patient #2's informed consent.<sup>57</sup>

23. Patient #2's record does not contain the name and phone number of an emergency contact.<sup>58</sup>

24. Respondent's recordkeeping for Patient #2 failed to meet the minimum standards of acceptable and prevailing practice.<sup>59</sup>

## **Patient #3**

### **Radiographs**

25. Patient #3 began seeing the Respondent in May 1995 and continued treating with the Respondent until at least August 2005.<sup>60</sup> Between 2000 and 2005, Respondent treated Patient #3 for problems with his crowns and provided root canal-related treatments.<sup>61</sup>

26. The Respondent ordered radiographs for Patient #3 that were not of sufficient diagnostic quality and do not meet the minimum standards of practice for radiographs.<sup>62</sup> The preoperative radiographs taken on October 3, 2000, for tooth 30 were taken at an angle that does not reveal the entire root structure of the tooth.<sup>63</sup> Additionally, the Respondent did not order any postoperative radiographs of tooth 30 on

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<sup>54</sup> T. 322.

<sup>55</sup> Ex. 100, Pt. #2, p. 7-11.

<sup>56</sup> Ex. 100, Pt. #2, p. 8; T. 324-326.

<sup>57</sup> *Id.*; T. 333-334.

<sup>58</sup> Ex. 100, Pt. #2, p. 12; T. 334.

<sup>59</sup> T. 334.

<sup>60</sup> Ex. 100, Pt. #3, p. 10, 1.

<sup>61</sup> T. 337-347.

<sup>62</sup> T. 342-45, 347.

<sup>63</sup> Ex. H; T. 343-344.

October 3, 2000, so that it cannot be determined whether the root canal reached the apex of the tooth.<sup>64</sup>

27. The radiographs for Patient #3 do not meet the minimum standards of acceptable and prevailing practice with regard to radiographs.<sup>65</sup>

## **Recordkeeping**

28. Respondent's November 16, 2004, progress notes for Patient #3 indicate that the patient presented with a sore tooth but the notes do not contain an actual diagnosis and do not contain any diagnostic information such as the examination of the suspected tooth and what was done to it.<sup>66</sup> In addition, there is no indication in the notes that a radiograph was taken.<sup>67</sup> The entry also lacks any documentation of the materials placed, whether an anesthetic was used, the temporary crown fabrication, or the next step in the treatment plan.<sup>68</sup> The Respondent also failed to document whether he discussed treatment options with Patient #3 and whether the patient consented to the care.<sup>69</sup>

29. Respondent's December 7, 2004, progress notes for Patient #3 indicate a root canal for tooth 13 for the patient's next visit; however, the notes do not contain any diagnostic information that would support a recommendation for a root canal on tooth 13.<sup>70</sup>

30. Respondent's October 3, 2000, progress notes for Patient #3 indicate that the Respondent finished a root canal treatment of tooth 30;<sup>71</sup> however, the notes lack a diagnosis and do not state what materials were used for disinfecting the canals.<sup>72</sup> The notes also do not indicate whether the Respondent discussed treatment options with Patient #3 and whether the patient consented to the care.<sup>73</sup> Finally, the treatment plan contained in Patient #3's file does not bear any written or dated treatment plan for a root canal on tooth 30.<sup>74</sup>

31. Respondent's recordkeeping for Patient #3 failed to meet the minimum standards of acceptable and prevailing practice.<sup>75</sup>

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<sup>64</sup> T. 344-345.

<sup>65</sup> T. 347.

<sup>66</sup> Ex. 100, Pt. #3, p. 2; T. 337.

<sup>67</sup> *Id.*, T. 337.

<sup>68</sup> T. 338.

<sup>69</sup> T. 338-339.

<sup>70</sup> T. 339.

<sup>71</sup> Ex. 100, Pt. #3, p. 6; T. 340.

<sup>72</sup> Ex. 100, Pt. #3, p. 6; T. 340-341.

<sup>73</sup> *Id.* at 6; T. 342.

<sup>74</sup> *Id.* at 27; T. 346.

<sup>75</sup> T. 346-347.



## Patient #4

### Radiographs/Treatment

32. Patient #4 began seeing the Respondent as her dentist in February 2002 and continued treating with him until at least September 2008.<sup>76</sup> During the treatment period, including from 2004 to 2006, Patient #4 sought treatment with the Respondent for crown seating, composite restoration, root canal treatments, and periodontal pathological treatments.<sup>77</sup>

33. Respondent's July 14, 2005, preoperative radiograph of Patient #4's teeth 29 and 30 taken prior to a root canal treatment was not of sufficient diagnostic quality because tooth 29 was not entirely on the film.<sup>78</sup> The radiograph did not meet the minimum standards of acceptable and prevailing practice with regard to radiographs.<sup>79</sup>

34. Respondent's records for Patient #4 fail to document whether the Respondent performed a diagnostic evaluation of the pulpal and periradicular status of teeth 29 and 30 before providing endodontic treatment on those teeth on July 21, 2005.<sup>80</sup>

35. Patient #4's records also fail to indicate whether the Respondent used a rubber (latex) dam during the root canal procedure.<sup>81</sup> The standard of care requires dentists to use a rubber dam when performing a root canal treatment to keep the field of operation in the oral cavity clean and dry.<sup>82</sup> Respondent also failed to document whether he used any medications to disinfect the canals for teeth 29 and 30.<sup>83</sup>

36. Respondent did not obtain a working radiograph for Patient #4's root canals on teeth 29 and 30 on July 21, 2005.<sup>84</sup> It is the standard of care to take a working radiograph during root canal therapy when the dentist starts to clean out the tooth so that the dentist knows exactly when he or she has reached the apex of the tooth.<sup>85</sup> To perform a root canal satisfactorily, the dentist should go precisely to the end of the tooth – not too deep and not too short. A working length film is taken to identify the exact length of the tooth from the incisal edge to the apex of the root.<sup>86</sup>

37. Apex locators, which are instruments with ultrasound technology that are used to determine the length of a tooth's root to the apex, cannot be used in place of a

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<sup>76</sup> Ex. 100, Pt. #4, p. 10, 1.

<sup>77</sup> T. 349-357.

<sup>78</sup> T. 354-355.

<sup>79</sup> T. 370.

<sup>80</sup> Ex. 100, Pt. #4, p.5; T. 361-362.

<sup>81</sup> T. 357-358. A rubber dam is a small piece of latex used to keep the field of operation in the oral cavity clean and dry while a dentist is working on the tooth.

<sup>82</sup> T. 357-358.

<sup>83</sup> T. 358-359. Contrary to the Committee's claim, Respondent did note in Patient #4's records that he used TF/TS (Thermafill and Thermaseal) as filling material. T. 878-880; Ex. 100, Pt. #4, p. 5.

<sup>84</sup> T. 361.

<sup>85</sup> T. 361.

<sup>86</sup> *Id.*

radiograph to determine whether a root canal is necessary or whether a root canal was done properly.<sup>87</sup> Moreover, the Respondent failed to document in Patient #4's records any use of the apex locator in the diagnostic process.<sup>88</sup>

38. The Respondent did not obtain a postoperative radiograph of teeth 29 and 30, which is necessary to determine whether the root canals on those teeth were performed correctly.<sup>89</sup> By failing to obtain postoperative radiographs for Patient #4, the Respondent did not meet the minimum standards of acceptable and prevailing practice for endodontic treatment.<sup>90</sup>

39. The fact that the Respondent did obtain radiographs of teeth 29 and 30 on May 18, 2006, 10 months after the endodontic treatment, does not alter the conclusion that his failure to do so immediately postoperatively was below the minimum standards of acceptable and prevailing practice. A postoperative radiograph taken ten months after a root canal would not alert the dentist to a substandard root canal until 10 months after the procedure.<sup>91</sup>

40. Respondent's treatment of Patient #4's teeth 29 and 30, including his performance of the root canal therapies, did not meet the minimum standard of acceptable and prevailing practice for dental treatment.<sup>92</sup>

41. Respondent's radiographs for Patient #4 do not meet the minimum standards of acceptable and prevailing practice.<sup>93</sup>

## **Recordkeeping**

42. Respondent's progress notes dated October 15, 2003, for Patient #4 indicate that Respondent seated crowns on teeth 28, 29, and 30; however, radiographs for Patient #4 do not show that the crowns were seated on teeth 29 and 30 on October 15, 2003.<sup>94</sup>

43. Respondent's January 5, 2005, progress notes for Patient #4 indicate that the Respondent provided a composite restoration for teeth 29 and 30 but the notes do not include a diagnosis, information on what materials were placed, or documentation of what anesthetic was used.<sup>95</sup> Additionally, the progress notes do not record whether the Respondent discussed with the patient treatment options for teeth 29 and 30 and whether Patient #4 consented to the treatment.<sup>96</sup>

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<sup>87</sup> T. 650-652; 845-846; 900-901.

<sup>88</sup> Ex. 100, Pt. #4, p. 5.

<sup>89</sup> T. 365-366.

<sup>90</sup> *Id.*

<sup>91</sup> T. 725-726.

<sup>92</sup> T. 370.

<sup>93</sup> T. 370.

<sup>94</sup> Ex. 100, Pt. #4, p. 6; T. 348-349.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* at 6; T. 352-353.

44. Respondent's July 21, 2005, progress notes for Patient #4 refer to the performance of root canal therapies on teeth 29 and 30 but the notes fail to identify by initials which provider performed the treatment.<sup>97</sup> The progress notes also fail to state whether the Respondent discussed treatment options with the patient and whether the Respondent obtained the patient's informed consent for the endodontic treatment.<sup>98</sup> In addition, the patient treatment plan is not dated, and the consent form was not signed and dated by the patient.<sup>99</sup> Patient #4's record contains an unsigned Consent for Dental Treatment form with a post-it note attached to it that states: "Please have pt. sign consent form at next visit."<sup>100</sup>

45. Respondent's recordkeeping for Patient #4 does not meet the minimum standards of acceptable and prevailing practice with regard to recordkeeping.<sup>101</sup>

## **Patient #5**

### **Recordkeeping**

46. Patient #5 began seeing Respondent for dental care in November of 2005, and continued until at least October of 2008.<sup>102</sup>

47. The Respondent saw Patient #5 on November 8, 2005, but the progress notes for that day do not contain a diagnosis, do not detail the treatments provided, do not document materials placed, and do not indicate whether the Respondent discussed treatment options with the patient and whether the patient consented to the care provided.<sup>103</sup> Despite references in the notes to conscious sedation, there are no records of the method's administration from November 8, 2005.<sup>104</sup>

48. Respondent's progress notes from December 7, 2005, lack a diagnosis, a record of all materials placed, treatments provided, and any record of the Respondent discussing treatment options with the patient and the patient's subsequent consent.<sup>105</sup> While the entry indicates the patient sought treatment for maxillary restoration, Respondent did not document what materials he used for placing the restoration.<sup>106</sup>

49. Respondent's progress notes from January 9, 2006, indicate that the patient presented for "tissue eval" and that treatment was necessary for tooth 7. The

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<sup>97</sup> Ex. 100, Pt. #4, p. 5; T. 353-354, 360.

<sup>98</sup> *Id.*; T. 360.

<sup>99</sup> *Id.* at 18, 23-24.

<sup>100</sup> *Id.* at 23-24; T. 364-365.

<sup>101</sup> T. at 370.

<sup>102</sup> Ex. 100, Pt. #5, p. 1-9.

<sup>103</sup> Ex. 100, Pt. #5, p. 9; T. 372-373.

<sup>104</sup> *Id.* at 9, 16-24; T. 374-375. The document "Sedation and Drug Administration Record" contains such records for conscious sedation treatments for January 23 and February 22, 2008.

<sup>105</sup> *Id.* at 9; T. 375-376.

<sup>106</sup> T. 376.

notes do not contain a diagnosis and do not detail the treatment necessary for tooth number 7 or the treatment recommendations proposed.<sup>107</sup>

50. Respondent's progress notes for January 24, 2006, do not document what treatment the Respondent provided to teeth 8 and 9.<sup>108</sup> Under the treatment plan, however, the Respondent recorded planned extractions for teeth 8 and 9 and then a bridge for teeth 7, 8, 9, and 10.<sup>109</sup> It is not clear from the progress notes whether teeth 8 and 9 were in fact extracted, and the Respondent does not provide a rationale for the treatment of teeth 8 and 9.<sup>110</sup> A document entitled "Consent for Treatment, Crown/Bridges/Veneers/Inlay/Onlay" is in Patient #5's file but it does not mention teeth 8 and 9, it lacks a date, and is not signed by Patient #5. There is nothing in Patient #5's record that would indicate that the patient gave informed consent to treatment of teeth 8 and 9.<sup>111</sup>

51. The recordkeeping for Patient #5 did not meet the minimum standards of accepted and prevailing practice.<sup>112</sup>

## **Patient #6**

### **Radiographs**

52. Patient #6 began treating with the Respondent for his dentistry care in December 2005 and continued treatments with the Respondent until at least March 2006.<sup>113</sup> Patient #6 sought treatments and therapies from the Respondent relating to a root canal during this time period.<sup>114</sup>

53. The radiographs taken by the Respondent on December 13, 2005, do not include the apices of all the teeth, do not cover completely the third molar area of the teeth, and some do not have the entire periapical area on the film.<sup>115</sup> Some of the radiographs in the full mouth set are overexposed and blurry and some are overlapping making it difficult to determine the diagnosis for particular teeth involved.<sup>116</sup>

54. The radiographs for Patient #6 fail to meet the minimum standards of acceptable and prevailing practice.<sup>117</sup>

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<sup>107</sup> T. 377.

<sup>108</sup> Ex. 100, Pt.# 5, p. 8.

<sup>109</sup> *Id.* at p. 10; T. 378.

<sup>110</sup> *Id.* at p. 8, 10; T. 378-379.

<sup>111</sup> *Id.*, p. 35-36; T. 379-380.

<sup>112</sup> T. 380.

<sup>113</sup> Ex. 100, Pt. #6, p. 5, 2.

<sup>114</sup> *Id.* at p. 2- 11.

<sup>115</sup> Ex. 100, Pt. #6, p.3; T. 381-383; Ex O.

<sup>116</sup> T. 382.

<sup>117</sup> T. 383.

## Recordkeeping

55. Respondent's progress notes indicate that he saw Patient #6 on December 13, 2005. However, the notes do not contain documentation of a clinical examination, documentation of existing oral health status, documentation for radiographic indication (even though notes indicate that a full mouth radiograph was taken), or a diagnosis.<sup>118</sup> Patient #6's records also lack the name and telephone number of an emergency contact.<sup>119</sup>

56. Respondent's recordkeeping for Patient #6 failed to meet the minimum standard of acceptable and prevailing practice.<sup>120</sup>

## Patient #7

### Radiographs

57. Patient #7 treated with the Respondent for dental care from November 2005 until at least October 2008.<sup>121</sup> During this time period, the Respondent treated Patient #7 for tooth decay, crown preparation and lengthening, tooth extraction, and root canal treatments.<sup>122</sup>

58. Based on the Respondent's progress notes, the Respondent provided extensive treatment to Patient #7 between November 30, 2005, and December 14, 2005; however, Patient # 7's records include only one panoramic radiograph of the patient's teeth, dated November 30, 2005, and do not include any periapical radiographs.<sup>123</sup> Given the extensive treatment provided, the taking and inclusion of only one panorex radiograph in the record is insufficient for diagnosis because panorex provide only a general representation of the teeth. They do not show the extent of the caries or the alveolar bone clearly for periodontal diagnosis. Panorex are only a partial diagnostic tool.<sup>124</sup>

59. The radiographs for Patient #7 were insufficient and failed to meet the minimum standards of acceptable and prevailing practice for the dental work performed between November 30, 2005 and December 14, 2005.<sup>125</sup>

## Recordkeeping

60. Respondent's progress notes reflect that he saw Patient #7 on December 14, 2005; however, the notes do not indicate the reason for the patient's visit or provide

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<sup>118</sup> *Id.*; T. 381-85.

<sup>119</sup> *Id.* at 7; T. 385-386.

<sup>120</sup> T. 386.

<sup>121</sup> Ex. 100, Pt. #7, 2-3.

<sup>122</sup> *Id.* at p. 2-3, 12, 14; T. 388.

<sup>123</sup> T. 386-87, Ex. P.

<sup>124</sup> T. 389.

<sup>125</sup> T. 388.

any documentation of a clinical examination or existing health status.<sup>126</sup> The progress notes only contain a partial diagnosis specific to the decay found on teeth 6-9.<sup>127</sup> The progress notes also lack documentation of all the materials placed for the temporization procedure.<sup>128</sup>

61. Respondent's recordkeeping for Patient #7 failed to meet the minimum standard of acceptable and prevailing practice.<sup>129</sup>

## **Patient #8**

### **Radiographs/Treatment**

62. Patient #8 treated with Respondent for dental care from December 2005 until at least March 2006.<sup>130</sup> During this time period, Respondent treated Patient #8 for crown and bridge replacement and performed a root canal on January 19, 2006, for tooth 27.<sup>131</sup> Patient #8 began his root canal treatment with a prior dentist but sought treatment from the Respondent because he wanted sedation during the procedure due to his gag reflex.<sup>132</sup>

63. The standard of care for root canal therapy requires a preoperative radiograph and a postoperative radiograph.<sup>133</sup>

64. Postoperative radiographs are necessary to confirm that a root canal procedure was performed adequately and specifically that the provider has gotten all the way to the tip of the tooth's root in the pulp and removed all of the diseased, infected or necrotic tissue.<sup>134</sup>

65. Patient #8's records contain only one panoramic radiograph dated January 9, 2006.<sup>135</sup> Even if this radiograph was misdated and mounted backwards as Respondent claims, so as to appear to reflect tooth 22 instead of tooth 27,<sup>136</sup> the Respondent failed to take two radiographs of tooth 27 as required by the standard of care for root canal therapy.

66. The Respondent's radiographs for Patient #8 fail to meet the minimum standards of acceptable and prevailing practice.<sup>137</sup>

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<sup>126</sup> Ex. 100, Pt. #7, p. 3; T. 389.

<sup>127</sup> *Id.*; T. 389-390.

<sup>128</sup> *Id.*; T. 390.

<sup>129</sup> T. 390.

<sup>130</sup> Ex. 100, Pt. #8, 2, 4, 34.

<sup>131</sup> *Id.* at 1-4, 5; T. 835.

<sup>132</sup> Ex. 334, p. 1022.

<sup>133</sup> T. 808.

<sup>134</sup> T. 343-345.

<sup>135</sup> Ex. 100, Pt. #8; T. 901-902.

<sup>136</sup> T. 904-906; Ex. 334, p. 1022.

<sup>137</sup> T. 844-845.

67. The Respondent's treatment of Patient #8's tooth 27 did not meet the minimum standards of acceptable and prevailing practice for dental treatment.<sup>138</sup>

### **Recordkeeping**

68. Respondent's progress notes from February 27, 2006 for Patient #8 indicate that the Respondent prepared tooth 9 for a crown and performed additional "buildup" of the tooth on that day. The Respondent further noted that a root canal of tooth 9 was determined to be not necessary. Patient #8's file lacks any radiograph of tooth 9 dated February 27, 2006, as well as any information to support Respondent's decision or rationale to not perform a root canal.<sup>139</sup>

69. There is no indication in Respondent's progress notes that Respondent performed diagnostic evaluations of the pulpal and periradicular status of tooth 27 before providing endodontic treatment on January 19, 2006.<sup>140</sup> Nor do the notes indicate that the Respondent made a pulpal or periradicular diagnosis of the status of tooth 27 prior to providing endodontic treatment.<sup>141</sup> Finally, the Respondent did not state in the January 19, 2006, progress notes whether he used any medications to disinfect the canal during instrumentation, whether he used rubber dam isolation for tooth 27, and whether he performed a restoration of tooth 27.<sup>142</sup>

70. The progress notes for Patient #8 did not consistently contain documentation of radiographic interpretation.<sup>143</sup>

71. The Respondent's recordkeeping for Patient #8 failed to meet the minimum standards of acceptable and prevailing practice.<sup>144</sup>

### **Patient #9**

### **Recordkeeping**

72. The Respondent's progress notes from February 20, 2006, for Patient #9 indicate that crowns were seated on teeth 30 and 15;<sup>145</sup> however, the notes do not document the performance of crown preparation for teeth 15 and 30 prior to the crown seat.<sup>146</sup> The progress notes also lack a diagnosis for the crown seat on teeth 30 and 15, as well as documentation of the initial status of teeth 30 and 15.<sup>147</sup>

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<sup>138</sup> T. 835-840.

<sup>139</sup> Ex. 100, Pt. #8, p.3; T. at 841-842.

<sup>140</sup> Ex. 100, Pt. #8, p. 3; T. 837-838.

<sup>141</sup> *Id.*

<sup>142</sup> Ex. 100, Pt. #8, p. 3; T. 837-840.

<sup>143</sup> T. 843-44.

<sup>144</sup> T. at 844.

<sup>145</sup> Ex. 100, Pt. #9, p. 32; T. 846-847.

<sup>146</sup> *Id.*; T. 847.

<sup>147</sup> *Id.* at 32; T. 848.

73. The Respondent's recordkeeping for Patient #9 failed to meet the minimum standards of acceptable and prevailing practice.<sup>148</sup>

## **Patient #10**

### **Radiographs/Treatment**

74. Patient #10 began treating with the Respondent for dental care in November 2005 and continued seeing the Respondent for dental care until at least November 2007.<sup>149</sup> The Respondent provided extensive treatments to Patient #10 including a crown for tooth 4 and root canals for teeth 6 and 21, performed on November 28, 2005.<sup>150</sup>

75. Respondent's November 28, 2005, progress notes for Patient #10 lack a diagnosis for teeth 4, 6, and 21, a pulpal and periradicular diagnosis of the status of teeth 4, 6, and 21 before endodontic treatment, and a documented radiographic interpretation.<sup>151</sup>

76. Patient #10's records do not state that the Respondent used rubber dam isolation when providing the treatments to teeth 4, 6, and 21.<sup>152</sup> In addition, Patient #10's records do not include documentation of any medications used by the Respondent to disinfect the canals during instrumentation of teeth 6 and 21.<sup>153</sup>

77. Respondent's treatment of Patient #10's teeth 4, 6, and 21 did not meet the minimum standards of acceptable and prevailing practice for dental treatment.<sup>154</sup>

### **Recordkeeping**

78. The Respondent's November 28, 2005, progress notes for Patient #10 do not contain a notation that the Respondent obtained the patient's informed consent for the endodontic treatment for teeth 4, 6, and 21 that was performed on that date.<sup>155</sup> In addition, the notes suggest that periodontal surgery was performed on tooth 3, but the notes do not contain a diagnosis or indicate what kind of surgery was performed and why it was necessary.<sup>156</sup>

79. Respondent's recordkeeping for Patient #10 did not meet the minimum standards of acceptable and prevailing practice.<sup>157</sup>

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<sup>148</sup> T. at 848.

<sup>149</sup> Ex. 100, Pt. #8, p. 1-5, 27-29.

<sup>150</sup> T. 848-849; Ex. 100, Pt. #10, p. 5.

<sup>151</sup> T. 850.

<sup>152</sup> T. 848-49; Ex. 100, Pt. #10, p. 5.

<sup>153</sup> *Id.*

<sup>154</sup> T. 851.

<sup>155</sup> Ex. 100, Pt. #10, p. 5; T. 849.

<sup>156</sup> T. 850-851.

<sup>157</sup> T. 851.



## Patient #11

### Recordkeeping

80. Respondent's progress notes for Patient #11 report that the Respondent saw the patient on December 13, but the notation does not indicate a year, a diagnosis, or documentation as to the patient's existing oral health status.<sup>158</sup> The patient's record also includes a treatment plan that is not dated.<sup>159</sup> In addition, the Respondent took a radiograph of the patient on December 13, 2005, but he failed to document a radiographic interpretation.<sup>160</sup>

81. Respondent's recordkeeping for Patient #11 did not meet the minimum standards of acceptable and prevailing practice.<sup>161</sup>

### Conscious Sedation

82. Conscious sedation renders patients less than fully conscious, but still able to respond to discomfort (noxious stimuli) and verbal cues. It is administered in order to reduce anxiety and pain levels associated with or in anticipation of certain dental procedures so that a patient can participate in the rendering of those treatments or procedures.<sup>162</sup> The main concern with using conscious sedation is that it can result in general anesthesia, which is total unconsciousness and non-responsiveness. In such cases, the patient is at risk of stopping breathing and must be resuscitated in order to survive.<sup>163</sup> Additionally, since no two patients respond to the same drug dosage in exactly the same manner, the dentist must be able to manage conscious sedation on an individual basis.<sup>164</sup>

83. The administration of conscious sedation includes monitoring the patient.<sup>165</sup> The standard of care for monitoring patients under conscious sedation requires that the individual administering the sedation is physically present and "actively monitoring" the patient during the course of time when the patient is under the influence of medications and rendered less than fully conscious.<sup>166</sup> This is the standard of care now and was the standard of care in 2005 and 2006.<sup>167</sup> Monitoring includes ensuring that the patient can breathe and that their heart is beating.<sup>168</sup> The standard of care from December 2005 to January 2006 also required monitoring to begin at the time of the administration of the medication and to continue until the patient had recovered satisfactorily from the effects of the medication so that any risk to the patient's safety

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<sup>158</sup> Ex. 100, Pt. #11, p. 1; T. 852, 854.

<sup>159</sup> *Id.*; T. 853.

<sup>160</sup> Ex. 100, Pt. #11; T. 854.

<sup>161</sup> T. 855.

<sup>162</sup> T. 84.

<sup>163</sup> T. 85.

<sup>164</sup> T. 86-87.

<sup>165</sup> T. 98-99.

<sup>166</sup> T. 103-104, 111-112.

<sup>167</sup> T. 103.

<sup>168</sup> T. 104.

would be eliminated.<sup>169</sup> In addition to using monitors to measure the patient's respiratory and heart rates, administration of conscious sedation requires constant vigil and continuous physical observation of the patient by the dentist administering the conscious sedation.<sup>170</sup>

84. In 2007, the Minnesota Board of Dentistry modified the rules governing conscious sedation by dentists to specifically permit treating doctors without conscious sedation certification to employ a certified dentist to administer the sedation with the requirement that the certified dentist remain in the operator room and "continually monitor" the patient until all dental services are completed.<sup>171</sup>

85. In January 2006, the Respondent completed the Conscious Sedation Training Program offered through the Continuing Dental Education Program at the University of Minnesota's School of Dentistry.<sup>172</sup> The program involved 60 hours of instruction, 24 hours of clinical experience, and at least 12 individual conscious sedation cases.<sup>173</sup> The School of Dentistry sent Respondent a verification letter on February 16, 2006, and the Respondent was certified to administer conscious sedation on or after that date.<sup>174</sup>

86. Until February 16, 2006, the Respondent was not qualified to administer conscious sedation or to monitor sedated patients.<sup>175</sup>

87. Before the Respondent became certified in conscious sedation, he hired Dr. Joseph Shama, a conscious sedation-certified dentist, to sedate patients at his Edina practice.<sup>176</sup> After hiring Dr. Shama, the Respondent and his Operations Manager, Diane Bednar, reviewed the conscious sedation rules to determine whether they could structure the practice to meet the growing demand for conscious sedation by having Dr. Shama administer the conscious sedation and the Respondent provide the dental care to the sedated patient.<sup>177</sup> Neither the Respondent nor Ms. Bednar believed there was any rule or regulation that would prohibit the practice from rendering services in this manner.<sup>178</sup> Additionally, they did not believe that this proposed setup ran afoul of the ADA Guidelines on conscious sedation.<sup>179</sup>

88. Between December 2005 and January 2006, there were numerous instances when Dr. Shama would administer the conscious sedation and the

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<sup>169</sup> T. 103-104; See, Minn. Rule 3100.3600, Subp. 2B (2005).

<sup>170</sup> T. 105.

<sup>171</sup> T. 149-150; See, Minn. Rule 3100.3600, Subp. 10A(2) (2007).

<sup>172</sup> Ex. 328, p. 8, 11.

<sup>173</sup> *Id.* at 8.

<sup>174</sup> *Id.* at 8; T. 98.

<sup>175</sup> T. 107.

<sup>176</sup> T. 502-503; Ex. 328, p. 8, 11, and Ex. 329.

<sup>177</sup> T. 502-504. Ms. Bednar's job duties included ensuring compliance with relevant rules, regulations, and statutes. T. 503.

<sup>178</sup> T. 503.

<sup>179</sup> T. 504.

Respondent would then provide dental care to the sedated patient.<sup>180</sup> In such situations, the Respondent had a duty to ensure that the patient was constantly monitored by Dr. Shama so that no untoward event occurred as a result of some sedation problem or complication.<sup>181</sup>

89. After administering the conscious sedations to the Respondent's patients, Dr. Shama performed other services such as conducting post-operative and consultation appointments with other patients, viewing radiographs, answering questions, and completing paperwork as necessary.<sup>182</sup> The consultation room at the Edina practice was located approximately five feet away from the treatment rooms.<sup>183</sup> During those occasions when he had consultation appointments scheduled while the Respondent was with a sedated patient, Dr. Shama was away from the sedated patient and not monitoring the patient's respiratory status or watching for any untoward reaction. Dr. Shama conceded that on occasion he was away from the sedated patients for "second[s] to minutes."<sup>184</sup> Otherwise, Dr. Shama would take a chair from the waiting room and put it at the threshold of the treatment room door in order to view the patient while at the same time answering questions about radiographs or completing paperwork.<sup>185</sup>

90. Reviewing charts and radiographs and conducting consultations with other patients takes a significant amount of time and attention. Conducting these activities while also monitoring a sedated patient diverts attention away from the sedated patient and would be a breach of the minimum standard of care, which requires "actively monitoring" the sedated patient.<sup>186</sup>

91. Between December 2005 and February 15, 2006, whenever Dr. Shama was out of the operatory or not sitting at its threshold after having administered conscious sedation to one of Respondent's patients, or whenever Dr. Shama's attention was diverted away from the sedated patient by reviewing charts or completing paperwork, the Respondent was in effect monitoring the sedated patients he was treating without having completed the training and requirements to administer sedation. By monitoring the sedated patients himself and by failing to ensure that a certified dentist was actively monitoring the sedated patient, Respondent violated the minimum standards of accepted and prevailing practice with respect to conscious sedation practice.<sup>187</sup> The record reflects that the Respondent violated these standards of practice on December 14, 2005; January 18, 2006; and January 24, 2006.

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<sup>180</sup> T. 502.

<sup>181</sup> T. 112.

<sup>182</sup> Ex. 330, p. 1102.

<sup>183</sup> *Id.*

<sup>184</sup> Ex. 332, p. 6.

<sup>185</sup> Ex. 332, p. 3; T. 814-815.

<sup>186</sup> T. 112-116.

<sup>187</sup> T. 107-114.

**December 14, 2005**

92. On December 14, 2005, Dr. Shama administered conscious sedation to Patient #7 at approximately 1:15 p.m. for a root canal procedure performed by the Respondent. The patient remained under conscious sedation until approximately 4:00 p.m.<sup>188</sup> The minimum standard of care during the procedure required constant monitoring of the patient by a conscious sedation-certified dentist.<sup>189</sup> Dr. Shama, who was the only certified conscious sedation dentist at Respondent's practice at that time, was scheduled to provide professional services to six other patients during the time that Patient #7 was sedated.<sup>190</sup>

93. The patient records indicate that Dr. Shama did provide dental services to the six other patients on his schedule during the time that Patient #7 was sedated.<sup>191</sup> Dr. Shama saw Patient #14 who presented for a post-operative appointment following a tooth extraction. During the appointment, a radiograph of the extraction site was taken, which only a dentist can order.<sup>192</sup> Extraction of a root tip was planned and a treatment plan recorded, which only a dentist can initiate and perform.<sup>193</sup> Dr. Shama consulted and discussed treatment options with Patient #12 regarding an implanted tooth and signed a progress note to that effect.<sup>194</sup> Patient #15 had an oral evaluation regarding teeth extraction with Dr. Shama during which the dentist discussed treatment alternatives, risks, and complications, all of which other staff could not perform.<sup>195</sup> Dr. Shama also planned the teeth extraction and wrote a prescription for the patient.<sup>196</sup> Dr. Shama met with Patient #16 for an oral surgery consultation regarding teeth extraction during which they discussed in detail the treatment alternatives, risks, and complications associated with the extraction.<sup>197</sup> Dr. Shama ordered a radiograph, planned the extraction, and signed a prescription for this patient.<sup>198</sup> Dr. Shama met with Patient #17 for an oral surgery consultation for teeth extraction during which Dr. Shama discussed treatment alternatives, risks, and complications of the procedure with the patient in

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<sup>188</sup> Ex. 100, Pt. #7, p. 3, 8; T. 51-52; Ex. 127, L-32.

<sup>189</sup> T. 109-112.

<sup>190</sup> Ex. 127, L-23.

<sup>191</sup> Ex. 100, Pts. #14, #12, #15, #16, #17, #18; Ex. 127, L-32.

<sup>192</sup> Ex. 100, Pt. #14, p. 2; Minn. Stat. §150A.05 subd. 1(4). Patient #14's appointment was scheduled for 2:15 p.m. Ex. 127, L-32.

<sup>193</sup> Ex. 100, Pt. #14, p. 6. T. 306 (treatment planning is part of the continuous care by a dentist and should happen between diagnoses and treatment); Minn. Stat. §150A.05, subd. 1(1) and subd. 1a; Minn. R. 3100.8300-3100.8700 (noting that only a dentist can sign a prescription).

<sup>194</sup> Ex. 100, Pt. #12, p. 26, 36-7; Ex. 127; T. 62. Patient #12 had a one hour long appointment scheduled for 2:30. Ex. 127, L-32.

<sup>195</sup> Ex. 100, Pt. #15, p. 2, 8; Ex. 127, L-32; T. 64, 116. Patient #15 had an appointment for 2:45 p.m. Ex. 127, L-32.

<sup>196</sup> Ex. 100, Pt. #15, p. 6, 11.

<sup>197</sup> Ex. 100, Pt. #16, p. 1, 11, 19, 20, 23, 24; Ex. 127; T. 65. Patient #16 was scheduled for a 3:00 p.m. appointment. Ex. 127, L-32.

<sup>198</sup> Ex. 100, Pt. #16, p. 6, 12, 23.

detail.<sup>199</sup> Dr. Shama planned the extraction with the patient and signed a prescription.<sup>200</sup> Patient #18 also consulted with Dr. Shama for a tooth extraction.<sup>201</sup> Dr. Shama made a record of the impacted tooth, referred the patient to an orthodontist, and signed a progress note.<sup>202</sup>

### January 18, 2006

94. On January 18, 2006, Dr. Shama administered conscious sedation to Respondent's Patient #10 at 3:15 p.m. The patient remained under conscious sedation until about 7:30 p.m.<sup>203</sup> The minimum standard of care during the procedure required constant monitoring of the patient by a conscious sedation-certified dentist.<sup>204</sup> Dr. Shama had three other patients scheduled for various appointments during the time Patient #10 was sedated.<sup>205</sup> Dr. Shama met with Patient #13 for an oral surgery consultation on teeth extraction.<sup>206</sup> They discussed treatment alternatives, risks, and complications involved with the procedure, and Dr. Shama ultimately recorded a treatment plan for the extraction.<sup>207</sup> Dr. Shama also met with Patient #19 for an oral surgery consultation related to teeth extraction.<sup>208</sup> Dr. Shama discussed the treatment alternatives, risks, and complications with the patient and later recorded a treatment plan for an extraction.<sup>209</sup> Patient #20 also met with Dr. Shama regarding for an oral surgery consultation for teeth extraction.<sup>210</sup> The patient and the dentist discussed in detail the treatment alternatives, risks, and complications associated with the procedure, and Dr. Shama ultimately planned the extraction and signed a prescription.<sup>211</sup> Dr. Shama also initialed the progress note for the patient meeting.<sup>212</sup>

### January 24, 2006

95. On January 24, 2006, Dr. Shama administered conscious sedation to Patient #5 at approximately 2:10 p.m. The patient remained under conscious sedation until approximately 4:30 p.m.<sup>213</sup> The minimum standard of care during the procedure

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<sup>199</sup> Ex. 100, Pt. #17, p. 1, 2, 8, 11, 12; Ex. 127, L-32. The schedule listed Patient #17's appointment as 3:20 p.m. Ex. 127, L-32.

<sup>200</sup> Ex. 100, Pt. #17, p. 1, 8, 28.

<sup>201</sup> Ex. 100, Pt. #18, p. 1, 9; Ex. 127, L-32; T. 66-67. Patient #18 had a 3:25 p.m. appointment. Ex. 127, L-32.

<sup>202</sup> Ex. 100, Pt. #18, p. 1.

<sup>203</sup> Ex. 100, Pt. #10, p. 19; T. 55-56, 60-61; Ex. 127, L-79.

<sup>204</sup> T. 109-112.

<sup>205</sup> Ex. 127, L-79.

<sup>206</sup> Ex. 100, Pt. #13, p. 1, 6, 8; Ex. 127, L-79; T. 67-68. Patient #13 had a 3:15 p.m. appointment. Ex. 127, L-79.

<sup>207</sup> Ex. 100, Pt. #13, p. 1, 6, 8, 9, 17.

<sup>208</sup> Ex. 100, Pt. #19, p. 1, 2; Ex. 127, L-79; T. 68. Patient #19's appointment was scheduled for 3:30 p.m. Ex. 127, L-79.

<sup>209</sup> Ex. 100, Pt. #19, p. 1, 2, 6, 11-12.

<sup>210</sup> Ex. 100, Pt. #20, p. 1, 3-4, 6; Ex. 127, L-79; T. 69. Patient #20 had a 3:45 p.m. appointment scheduled for 3:45 p.m. Ex. 127, L-79.

<sup>211</sup> Ex. 100, Pt. #20, p. 1, 4, 6-8.

<sup>212</sup> *Id.* at 1; T.69-70.

<sup>213</sup> Ex. 100, Pt. #5, p. 22; T. 57; Ex. 127, L-83.

required constant monitoring of the patient by a conscious sedation-certified dentist.<sup>214</sup> Dr. Shama had seven other patients scheduled during the time that Patient #5 was sedated.<sup>215</sup> Dr. Shama met with Patient #24 for a post-operative appointment following teeth extraction performed on January 18, 2006.<sup>216</sup> Dr. Shama met with Patient #21 for an oral surgery consultation for teeth extraction.<sup>217</sup> After recommending extraction of all of Patient #21's teeth, Dr. Shama signed a prescription for the patient.<sup>218</sup> Patient #25 also presented for an oral surgery consultation at 2:30 p.m.<sup>219</sup> Dr. Shama was running behind schedule and the office offered to reschedule the patient; however, Dr. Shama did see Patient #25, if briefly, and the record indicated that Dr. Shama was "scheduled for sedation with [the Respondent] this afternoon."<sup>220</sup> Dr. Shama also saw Patient #22 for a consultation on teeth extraction.<sup>221</sup> Dr. Shama discussed with this patient the treatment options, risks, and complications in a detailed manner. Dr. Shama eventually formulated an extraction plan, and he signed a prescription for the patient.<sup>222</sup> Dr. Shama also met with Patient #26 for a consultation on teeth extraction.<sup>223</sup> Patient #27 presented shortly thereafter for a consultation on teeth extraction with Dr. Shama.<sup>224</sup> The two discussed in detail the treatment alternatives, risks, and complications of the extraction, and Dr. Shama planned the extraction and signed a prescription for the patient.<sup>225</sup> Finally, Patient #23 met with Dr. Shama for a consultation on teeth extraction.<sup>226</sup> Dr. Shama and the patient discussed, in detail, the treatment alternatives, risks, and complications associated with the extraction, with Dr. Shama developing an extraction plan and writing a prescription for the patient.<sup>227</sup>

96. By conducting consultations with patients when he was required to be monitoring patients under conscious sedation as the only dentist certified to administer the technique at the time, Dr. Shama failed to "actively monitor" the sedated patients. The record demonstrates that Dr. Shama's attention was diverted from the sedated patient and that on occasion he was physically not present in the operatory with the Respondent.<sup>228</sup>

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<sup>214</sup> T. 109-112.

<sup>215</sup> Ex. 127, L-83.

<sup>216</sup> Ex. 100, Pt. #24, p. 1, 3, 8; Ex. 127, L-83; T. 72. Patient #24 had a 2:00 p.m. appointment. Ex. 127, L-83.

<sup>217</sup> Ex. 100, Pt. #21, p. 1, 12; Ex. 127, L-83. Patient 21 had a 3:30 p.m. appointment. Ex. 127, L-83.

<sup>218</sup> Ex. 100, Pt. #21, p. 1, 13, 25.

<sup>219</sup> Ex. 100, Pt. #25, p. 11; Ex. 127, L-83; T. 73-74. Patient #25's appointment was scheduled for 2:30 p.m. Ex. 127, L-83.

<sup>220</sup> Ex. 100, Pt. #25, p. 11; T. 73-74.

<sup>221</sup> Ex. 100, Pt. #22, p. 2, 9, 16-17; Ex. 127 L-83; T. 68. Patient #22 had a 2:45 p.m. appointment. Ex. 127, L-83.

<sup>222</sup> Ex. 100, Pt. #22, p. 2, 9, 16-19.

<sup>223</sup> Ex. 100, Pt. #26, p.3; Ex. 127, L-83; T. 75. Patient #26 was also scheduled for 2:45 p.m. Ex. 127, L-83.

<sup>224</sup> Ex. 100, Pt. #27, p. 1, 3, 5; Ex. 127, L-83; T. 75-76. The appointment was set for 3:15 p.m. Ex. 127, L-83.

<sup>225</sup> Ex. 100, Pt. #27, p. 1, 3, 5-6.

<sup>226</sup> Ex. 100, Pt. #23, p. 1, 4, 11; Ex. 127, L-83. Patient #23 had a 3:45 p.m. appointment. Ex. 127, L-83.

<sup>227</sup> Ex. 100, Pt. #23, p. 1, 4, 10-13.

<sup>228</sup> T. 101, 111-116. See also Minn. R. 3100.3600 Subp. 3.B.

97. Dr. Shama's absence from the operatory establishes that the Respondent monitored sedated patients before he earned his certification in conscious sedation in February 2006.<sup>229</sup> By failing to assure active monitoring of the sedated patients by Dr. Shama, Respondent failed to meet the standard of care with respect to conscious sedation treatment.<sup>230</sup>

### **Sanitary and Safety Conditions of Chicago Avenue Minneapolis Office**

98. The purpose of infection control is to protect patients, staff, doctors, and other individuals from the transmission of infectious pathogens.<sup>231</sup> The dentist-owner of the practice is responsible for infection control,<sup>232</sup> as are treatment providers.<sup>233</sup> The Respondent, as the sole owner of Family and Cosmetic Gentle Dentistry and a licensed provider, is responsible for the safety and sanitary conditions and infection control of and in his clinics.<sup>234</sup> Likewise, each dental healthcare provider, including dental hygienists and assistants, is responsible to follow the rules and regulations regarding safety and sanitary conditions within the dental office.<sup>235</sup>

99. The Minnesota Board of Dentistry Rules for infection control reference and require dental health care personnel to comply with the most current infection control recommendations, guidelines and procedures from the Centers for Disease Control.<sup>236</sup> The CDC publishes Guidelines for Infection Control in Dental Healthcare Settings (CDC Guidelines or Guidelines).<sup>237</sup> The Guidelines provide that "critical instruments sterilized unwrapped should be transferred immediately by using aseptic technique from the sterilizer to the actual point of use. Critical instruments should not be stored unwrapped."<sup>238</sup> Critical instruments are those which come into contact with the mucosal tissue or blood, such as burs, which are tools used to remove decay from a tooth.<sup>239</sup>

100. All items that have direct contact with the patient's mouth need to be either sterilized in sealed bags or initially opened at the first visit.<sup>240</sup> Brand-new unopened packages of burs may go in a plastic bin in an operatory drawer with a lid.<sup>241</sup> If the bur is not in a package, however, it must be sterilized and bagged until used.<sup>242</sup>

101. At the Respondent's clinics, burs were sterilized and then stored in open containers in the operatories, unbagged or unwrapped.<sup>243</sup> Likewise, handpieces at

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<sup>229</sup> T. 96, 98.

<sup>230</sup> T. 103.

<sup>231</sup> T. 856.

<sup>232</sup> *Id.* See also Ex. 129, p. 4; T. 591, 856.

<sup>233</sup> T. 856.

<sup>234</sup> *Id.*

<sup>235</sup> T. 414-415.

<sup>236</sup> See Minn. Rule 3100.6300, subp. 11.

<sup>237</sup> T. 856-57. CDC Guidelines, 2003 version, were entered into evidence as Ex. 129.

<sup>238</sup> T. 857. Ex. 129, p. 25.

<sup>239</sup> T. 429-430, 857-858.

<sup>240</sup> T. 421.

<sup>241</sup> T. 422.

<sup>242</sup> *Id.*

<sup>243</sup> T. 430-431.

Respondent's clinics were sterilized and then placed loose in a bin or in a drawer in the operatory unbagged.<sup>244</sup> If a bin is uncovered, the unbagged instruments can become contaminated if any object comes into contact with the instruments.<sup>245</sup> Likewise, burs stored in a covered or uncovered plastic container would become contaminated if a staff member reached into the container to retrieve a bur without wearing gloves.<sup>246</sup> Respondent's dental hygienist, Gail Kolden, observed staff members at Respondent's clinics reach into plastic bins without gloves "all the time."<sup>247</sup>

102. On August 25, 2005, an investigator with the Minnesota Attorney General's Office inspected Respondent's practice located at 5401 Chicago Avenue South, Minneapolis (Chicago Avenue Location). A photograph taken during the inspection shows a container in operatory #3 holding unwrapped burs.<sup>248</sup> Another photo of operatory #4 shows a container of unwrapped burs<sup>249</sup> and unwrapped bur blocks.<sup>250</sup>

103. The storage of the unwrapped burs at the Respondent's clinic is not consistent with acceptable and prevailing practice in dental healthcare relating to safety and infection control.<sup>251</sup>

104. Another "critical instrument" is an endodontic file, which is a small thin file used to perform root canal therapies and used to remove debris from a tooth and to shape it for root canal filling material.<sup>252</sup> A photo of Respondent's operatory #4 taken during the August 25, 2005, inspection shows a bin containing endodontic instruments, including an endodontic file, two unwrapped yellow foam blocks, and one unwrapped blue foam block containing endodontic files.<sup>253</sup>

105. Respondent's clinic did not store the endodontic files pictured in a manner consistent with acceptable and prevailing practice with respect to safety and infection control in dental healthcare.<sup>254</sup>

106. Similarly, a photo of operatory #4 taken during the inspection shows a basket holding various instruments including unwrapped foam blocks with endodontic files.<sup>255</sup> The storage of these files is inconsistent with the acceptable and prevailing practice for safety and infection control in dental healthcare.<sup>256</sup>

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<sup>244</sup> T. 431.

<sup>245</sup> *Id.*

<sup>246</sup> *Id.*

<sup>247</sup> T. 444-445. She also witnessed individuals putting other instruments into the bins without gloves. *Id.*

<sup>248</sup> T. 858; Ex. 105, p. D-18.

<sup>249</sup> T. 859; Ex. 105, p. D-23.

<sup>250</sup> T. 859-60; Ex. 105, p. D-24.

<sup>251</sup> T. 858-60.

<sup>252</sup> T. 860.

<sup>253</sup> Ex. 105, p. 6 and D-25; T. 860-61.

<sup>254</sup> T. 860-862.

<sup>255</sup> Ex. 105, p. D-26; T. 863.

<sup>256</sup> T. 863.



107. A photograph of operatory #4 taken during the August 25, 2005, inspection, also shows a plastic bag containing instruments with condensation on the bag itself.<sup>257</sup> The presence of condensation could cause microorganisms to grow and contaminate the instruments.<sup>258</sup>

108. A photograph of operatory #5 taken during the August 25, 2005, inspection, shows a drawer with both wrapped and unwrapped burs. The storage of these burs does not conform with acceptable and prevailing practice with respect to safety and infection control in dental healthcare.<sup>259</sup>

109. The dental instruments, burs, and files in Respondent's Chicago Avenue practice were not properly bagged, sterilized, and stored consistent with acceptable and prevailing practice, CDC guidelines, or the Board rules on infection control.

110. The CDC guidelines set forth that "[c]leaning is the necessary first step of any disinfection process," but "[w]hen a surface cannot be cleaned adequately, it should be protected with barriers."<sup>260</sup> Barriers include clear plastic wrap, bags, sheets, tubing and plastic-backed paper or other material impervious to moisture. If dental health professionals do not use any barriers, surfaces should then be "cleaned and disinfected between patients by using an EPA-registered hospital disinfectant with an HIV, HBV claim."<sup>261</sup> Birex is an example of a chemical disinfectant.<sup>262</sup> The CDC Guidelines also note the contamination risks for cloth furnishings "in areas of direct patient care" such as operatories where contaminated materials are handled and ultimately suggest that the "use of carpeted flooring and fabric upholstered furnishings in these areas should be avoided."<sup>263</sup> Birex cannot adequately disinfect a cloth chair.<sup>264</sup>

111. The investigator with the Minnesota Attorney General's Office took photographs of the Respondent's Chicago Avenue office on August 25, 2005, that show no barriers present on the air/water syringe, evacuation controls, or handpiece in operatory #1.<sup>265</sup> Likewise, photographs show that there were no barriers present in operatories #2, #3, #4, #5, and #6.<sup>266</sup> Operatory #4 also had a dental chair covered in vinyl and cloth without any plastic barriers on the chair.<sup>267</sup> A dental chair covered in this manner cannot be disinfected with Birex.<sup>268</sup>

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<sup>257</sup> Ex. 105, p. D-27.

<sup>258</sup> *Id.*; T. 647.

<sup>259</sup> Ex. 105, p. D-39; T. 864.

<sup>260</sup> Ex. 129, p. 28.

<sup>261</sup> *Id.* at 29.

<sup>262</sup> T. 866.

<sup>263</sup> Ex. 129, p. 30.

<sup>264</sup> T. 866.

<sup>265</sup> Ex. 105, p. D-5.

<sup>266</sup> *Id.* at D-10-51.

<sup>267</sup> Ex. 105, p. D-20; T. 866-867.

<sup>268</sup> T. 867.

112. Barriers were not used and surfaces were not properly disinfected in Respondent's Chicago Avenue practice in a manner consistent with acceptable and prevailing practice and the CDC Guidelines.<sup>269</sup>

113. Respondent's Chicago Avenue practice also exhibited general housekeeping and sanitation deficiencies. The ceiling in operatory #2 was cracked and had water stains.<sup>270</sup> A wall in operatory #4 was moist and spongy,<sup>271</sup> and the ceiling had a water stain around the vent.<sup>272</sup> In addition, the floor in operatory #4 was dusty and cobwebs were present in the corners of the wall.<sup>273</sup>

114. Additionally, the Minnesota Department of Labor and Industry conducted an Occupational Safety and Health Administration inspection of Respondent's Chicago Avenue practice on June 1, 2005.<sup>274</sup> The inspection revealed a visible roof leak and "visible mold growth in various locations of the facility."<sup>275</sup> The inspection also revealed that an Ultra Sonic instrument cleaning machine had been improperly modified when the machine's on/off switch ceased working.<sup>276</sup> The investigators also observed that staff did not allow sterilized and cleaned dental instruments to dry before bagging and that some sterilization equipment had visible residue build-up "on the inside of the equipment where instruments are supposed to be sterilized."<sup>277</sup> Finally, the investigators observed mold growth on a deteriorating cabinet shelf beneath the sterilization equipment.<sup>278</sup> The Department issued the Respondent a "Serious" violation for the hazards posed by the modifications to the Ultra Sonic machine.<sup>279</sup>

115. A leaking roof or ceiling, and the presence of cobwebs, dust and mold in a dental clinic is not consistent with the acceptable and prevailing practice for safety and infection control in a dental practice.<sup>280</sup> The Respondent's practice did not meet these minimum standards of acceptable and prevailing practice for safety, sanitation, and infection control for a dental practice.<sup>281</sup>

Based on the above Findings of Fact, the Administrative Law Judge makes the following:

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<sup>269</sup> T. 865-867.

<sup>270</sup> Ex. 105, p. 6 and D-14; T. 209.

<sup>271</sup> T. 216-217; Ex. 105, p. 7 and D-32.

<sup>272</sup> Ex. 105; T. 202.

<sup>273</sup> Ex. 105, p. 6-7 and D-30; T. 216.

<sup>274</sup> Ex. 104.

<sup>275</sup> *Id.*

<sup>276</sup> *Id.*, at p. 2. The machine did not always turn on and also shocked staff. *Id.*

<sup>277</sup> *Id.*

<sup>278</sup> *Id.*

<sup>279</sup> *Id.* at "Worksheet."

<sup>280</sup> T. 870.

<sup>281</sup> T. 870-871.

## CONCLUSIONS

1. The Board of Dentistry and the Administrative Law Judge have jurisdiction in this matter under Minn. Stat. §§ 14.50, 150A.08, 214.10, and 214.103.

2. The Complaint Committee of the Board gave proper notice of the hearing in this matter and all relevant substantive and procedural requirements of the statute and rule have been fulfilled.

3. The Committee has the burden of proof in this proceeding and must establish the facts at issue by a preponderance of the evidence.<sup>282</sup>

4. Minnesota Statutes § 150A.08, subd. 1, provides that the Board may suspend, revoke or take other disciplinary action against the license of a dentist for any of the following grounds:

...

(6) conduct unbecoming a person licensed to practice dentistry . . . , or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;

...

(10) failure to maintain adequate safety and sanitary conditions for a dental office in accordance with the standards established by the rules of the board;

...

(13) violation of, or failure to comply with, any other provisions of sections 150A.01 to 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board, section 144.335 or 595.02, subdivision 1, paragraph (d), or for any other just cause related to the practice of dentistry. Suspension, revocation, modification or limitation of any license shall not be based upon any judgment as to therapeutic or monetary value of any individual drug prescribed or any individual treatment rendered, but only upon a repeated pattern of conduct;

5. Pursuant to Minnesota Rule 3100.6200, "conduct unbecoming a person licensed to practice dentistry," as used in Minnesota Statutes § 150A.08, subd. 1(6), includes the following acts:

...

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<sup>282</sup> Minn. 4. 1400.7300, subp. 5. See also *In re Wang*, 441 N.W.2d 488, 492 (Minn. 1989).

B. gross ignorance or incompetence in the practice of dentistry and/or repeated performance of dental treatment which fall below accepted standards;

...

K. failing to maintain adequate safety and sanitary conditions for a dental office as specified in part 3100.6300.

6. Minnesota Rule 3100.9600, subp. 2, requires dentists to maintain dental records on each patient that contain the following components:<sup>283</sup>

Subp. 3. **Personal data.** Dental records shall include at least the following information:

- A. the patient's name;
- B. the patient's address;
- C. the patient's date of birth;
- D. if the patient is a minor, the name of the patient's parent or guardian;
- E. the name and telephone number of a person to contact in case of an emergency; and
- F. the name of the patient's insurance carrier and insurance identification number, if applicable.

Subp. 4. **Patient's reasons for visit.** When a patient presents with a chief complaint, dental records shall include the patient's stated oral health care reasons for visiting the dentist.

Subp. 5. **Dental and medical history.** Dental records shall include information from the patient or the patient's parent or guardian on the patient's dental and medical history. The information shall include a sufficient amount of data to support the recommended treatment plan.

Subp. 6. **Clinical examinations.** When emergency treatment is performed, items A, B, and C pertain only to the area treated. When a clinical examination is performed, dental records shall include:

- A. recording of existing oral health care status;
- B. any radiographs used; and
- C. the facsimiles or results of any other diagnostic aids used.

Subp. 7. **Diagnosis.** Dental records shall include a diagnosis.

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<sup>283</sup> Minn. Rule 3100.9600, subp. 2 (2005).

Subp. 8. **Treatment plan.** Dental records shall include an agreed upon written and dated treatment plan except for routine dental care such as preventive services. The treatment plan shall be updated to reflect the current status of the patient's oral health and treatment.

Subp. 9. **Informed consent.** Dental records shall include a notation that:

A. the dentist discussed with the patient the treatment options and the prognosis, benefits, and risks of each; and

B. the patient has consented to the treatment chosen.

Subp. 10. **Progress notes.** Dental records shall include a chronology of the patient's progress throughout the course of all treatment and postoperative visits. The chronology shall include all treatment provided, clearly identify the provider by name or initials, and identify all medications used and materials placed.

7. The Committee has established by a preponderance of the evidence that the Respondent engaged in conduct unbecoming a person licensed to practice dentistry by repeatedly performing dental treatments that fell below the standard of accepted care within the meaning of Minn. Stat. §150A.08, subd. 1(6) and Minn. R. 3100.6200B. Specifically, the Committee established that the Respondent failed to provide appropriate endodontic treatment to Patients 4, 8 and 10; the Respondent failed to take a sufficient number of radiographs and/or failed to take radiographs of diagnostic quality for the purpose of properly assessing the patient's dental health for patients 3, 4, 6, 7, and 8; and the Respondent failed to make or maintain adequate patient records on each patient at issue (Patients # 1-11) within the meaning of Minn. R. 3100.9600.

8. Minnesota Rule 3100.0100, subp. 8a (2005) defines "conscious sedation" as "a depressed level of consciousness induced by the administration of a pharmacological agent that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command."

9. Minnesota Rule 3100.3600 requires dentists to receive certification from the Board before they can administer conscious sedation. In order to obtain certification, a dentist must complete a minimum of 60 hours of didactic education and 24 hours of clinical experience to become clinically competent to administer conscious sedation. In addition, the dentist must complete an advanced cardiac life support course and complete an advanced or basic life support course every two years.<sup>284</sup>

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<sup>284</sup> Minn. Rule 3100.3600, subp. 3A.

10. The standards of care for administering conscious sedation are uniform and do not vary by the setting of the practice.<sup>285</sup>

11. Minnesota Rule 3100.3600, subp. 3B (2005), provides as follows:

A dentist shall be prepared and competent to diagnose, resolve, and reasonably prevent any untoward reaction or medical emergencies that may develop any time after rendering a patient in the state of conscious sedation. A dentist shall apply the current standard of care to monitor and evaluate a patient's blood pressure, pulse, respiratory function, and cardiac activity. The current standard of care to assess respiratory function shall require the monitoring of tissue oxygenation or the use of a superior method of monitoring respiratory function.

12. Prior to discharging the patient, the dentist shall ensure that the effects of the medication have sufficiently dissipated to a level where in-office monitoring is no longer required.<sup>286</sup>

13. In December 2005 and January 2006, the Respondent was not certified to administer conscious sedation or competent to monitor patients under conscious sedation.

14. The Committee has established that in December 2005 and January 2006, the Respondent failed to meet the standard of care and engaged in unprofessional conduct by knowingly allowing patients under conscious sedation to go without continuous active monitoring by a dentist certified in the administration of conscious sedation and by monitoring sedated patients himself without having completed the required training and education necessary to administer or monitor conscious sedation for patients.<sup>287</sup>

15. Pursuant to Minn. Rule 3100.6300, dental offices are required to meet minimum safety and sanitary conditions, including:

Subp. 2. **Premises.** The premises shall be kept neat and clean, and free of accumulations of rubbish, ponded water, or other conditions of similar nature which would have a tendency to create a public health nuisance.

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<sup>285</sup> T. 150-54.

<sup>286</sup> Minn. Rule 3100.3600, subp. 3C (2005).

<sup>287</sup> T. 103-104, 111-112; Minn. Stat. § 150A.08, subd. 1(6); Minn. Rule 3100.6200B; Minn. Rule 3100.3600. *Cf. Reyburn v. State Board of Optometry*, 78 N.W.2d 351, 355 (Minn. 1956) (The Legislature is not required to enumerate what specific acts or omissions constitute unprofessional conduct since the phrase "unprofessional conduct" provides a guide for and a limitation upon exercise by the Board of its statutory power to revoke a practitioner's license.); *See also, Pietsch v. Minn. Bd. Of Chiropractor Examiners*, 683 N.W.2d 303 (Minn. 2004).

Subp. 3. **Housekeeping facilities and services.** Housekeeping facilities and services necessary to assure comfortable and sanitary conditions for patients and employees shall be utilized.

...

Subp. 10. **Clean rooms.** Floors, walls, and ceilings of all rooms, including store rooms, shall be clean and free of any accumulation of rubbish.

Subp. 11. **Infection control.** Dental health care personnel shall comply with the most current infection control recommendations, guidelines, precautions, procedures, practices, strategies, and techniques specified in the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control publications of the Morbidity and Mortality Weekly Report (MMWR). . . .

16. The Committee has established by a preponderance of the evidence that the Respondent failed to maintain adequate safety and sanitary conditions for his dental office located at 5401 Chicago Avenue in Minneapolis within the meaning of Minn. Stat. § 150A.08, subd. 1(6) and (10) and Minn. Rule 3100.6200K and 3100.6300.

17. Minn. Stat. § 150A.08 empowers the Board to take disciplinary action against the Respondent, for his violations of statutes and rules.

18. The Committee has established by a preponderance of the evidence that Respondent's conduct justifies the Board of Dentistry imposing disciplinary action against Respondent's license.

19. Imposition of disciplinary action against the Respondent is in the public interest.

Based on the foregoing Conclusions, the Administrative Law Judge makes the following:

### **RECOMMENDATION**

IT IS HEREBY RECOMMENDED that the Minnesota Board of Dentistry take disciplinary action against the dental license of Robert L. Bodin.

Dated this 17<sup>th</sup> day of September 2009.

/s/ Steve M. Mihalchick by BLN  
STEVE M. MIHALCHICK  
Administrative Law Judge

## **NOTICE**

This Report is a recommendation, **not** a final decision. The Board of Dentistry will make the final decision after a review of the record. The Board may adopt, reject or modify the Findings of Fact, Conclusions and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Board shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Board. Parties should contact Marshal Shragg, Executive Director, Minnesota Board of Dentistry, 2829 University Avenue SE, Suite 450, Minneapolis, MN 55414 to find out how to file exceptions or present argument.